TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Healthcare Rehab Group

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-0364-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our provider has reviewed his note and is standing firm that all documentation is correct for this level of service."

Amount in Dispute: $380.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's documentation shows an expanded problem focused history and an examination that is problem focused. Because the CPT criteria for the code requires two of the following three criteria to be met, i.e. detailed history, detailed exam, and moderate complexity medical decision making, Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 22 & June 8, 2015	Evaluation & Management, established patient (99214)	$380.00	$342.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.203 defines the medical fee guidelines for reimbursement of professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-150 – Payer deems the information submitted does not support this level of service.
   - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 891 – No additional payment after reconsideration.

Issues

1. What are the criteria for documenting the level of service for CPT Code 99214?
2. Did the requestor support the level of service for CPT Code 99214 for each date of service as required by 28 Texas Administrative Code §134.203?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part,

> for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient.

The American Medical Association (AMA) CPT code description for 99214 is:

> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **A detailed history; A detailed examination; Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. [emphasis added]

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99214 are as follows:

- Documentation of the Detailed History:
  - "An *extended* [History of Present Illness (HPI)] consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions."
  - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient's positive responses and pertinent negatives for two to nine systems to be documented."
  - "A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] to be documented."

  The Guidelines state, "To qualify for a given type of history all three elements in the table must be met."
- Documentation of a Detailed Examination:
  - A "*detailed examination* …should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements [of the General Multi-System Examination table]. Alternatively, a detailed examination may include

performance and documentation of at least twelve elements … in two or more organ systems or body areas."

- Documentation of Decision Making of Moderate Complexity:
    - *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of treatment recommended are taken into account.
    - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
    - *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk."

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**."

2. For date of service 4/22/15, the submitted documentation supports that the requestor provided a review of six (6) elements of HPI, a review of four (4) systems, and one (1) area of PFSH. This meets the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of eight (8) elements of the General Multi-System Examination table, which does not meet the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met two (2) of the required key components of CPT Code 99214, the requestor did support this level of service.**

   For date of service 6/8/15, the submitted documentation supports that the requestor provided a review of five (5) elements of HPI, a review of three (3) systems, and one (1) area of PFSH. This meets the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of eight (8) elements of the General Multi-System Examination table, which does not meet the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met two (2) of the required key components of CPT Code 99214, the requestor did support this level of service.**

3. 28 Texas Administrative Code §134.203 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is $56.20.

   For CPT code 99214 on April 22, 2015, the relative value (RVU) for work of 1.50 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 1.527000. The practice expense (PE) RVU of 1.43 multiplied by the PE GPCI of 1.009 is 1.442870. The malpractice (MP) RVU of 0.10 multiplied by the MP GPCI of 0.772 is 0.077200. The sum of 3.047070 is multiplied by the Division conversion factor of $56.20 for a MAR of $171.25.

   For CPT code 99214 on June 8, 2015, the RVU for work of 1.50 multiplied by the GPCI for work of 1.018 is 1.527000. The PE RVU of 1.43 multiplied by the PE GPCI of 1.009 is 1.442870. The MP RVU of 0.10 multiplied by the MP GPCI of 0.772 is 0.077200. The sum of 3.047070 is multiplied by the Division conversion factor of $56.20 for a MAR of $171.25.

4. The total MAR for the disputed services is $342.50. The insurance carrier paid $0.00. A reimbursement of $342.50 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $342.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $342.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	November 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.